VOL. 5, No. 12 DECEMBER 1951

# CHRONICLE OF THE WORLD HEALTH ORGANIZATION

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## RECENT AND FORTHCOMING MEETINGS

**1951**

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| 7-25 May | Fourth World Health Assembly, Geneva |
| 18 May | WHO Regional Committee for the Western Pacific, first session, Geneva |
| 28-29 May | WHO Consultative Committee for Europe, first session, Geneva |
| 1-18 June | WHO Executive Board, eighth session, Geneva |
| 30 July-4 August | WHO Expert Committee on Insecticides, third session, Savannah, Ga. |
| 3-5 September | WHO Consultative Committee for Europe, second session, Geneva |
| 18-21 September | WHO Expert Committee on Health Statistics, Subcommittee on the Registration of Cases of Cancer as well as their Statistical Presentation, second session, Paris |
| 18-21 September | WHO Regional Committee for the Western Pacific, second session, Manila |
| 20-25 September | WHO Regional Committee for South-East Asia, fourth session, Rangoon |
| 24-27 September | WHO Regional Committee for Africa, first session, Geneva |
| 15-20 October | WHO Expert Committee on Environmental Sanitation, second session, Geneva |
| 15-20 October | WHO Expert Committee on Mental Health, Alcoholism Subcommittee, second session, Copenhagen |
| 15-20 October | WHO Expert Committee on Nursing, second session, Geneva |
| 22 October-3 November | European Seminar on Alcoholism, Copenhagen |
| 29 October-3 November | WHO Expert Committee on the International Pharmacopoeia, ninth session, Geneva |
| 5 November | WHO Expert Committee on the International Pharmacopoeia, Subcommittee on Non-Proprietary Names, third session, Geneva |
| 5-9 November | WHO Expert Committee on Maternity Care, first session, Geneva |
| 12-17 november | Second Seminar for European Sanitary Engineers, Rome |
| 16-20 November | WHO Expert Committee on Cholera, first session, New Delhi |
| 21-29 November | WHO Conference on Morbidity Statistics;<br>WHO Expert Committee on Health Statistics, third session, Geneva |
| 26-30 November | WHO Expert Committee on Trachoma, first session, Alexandria |
| 28- November-4 December | WHO Expert Committee on Insecticides, fourth session, Geneva |
| 3-7 December | WHO Expert Committee on Public Health Administration, first session, Geneva |
| 3-8 December | WHO Expert Committee on Biological Standardization, fifth session, Geneva |
| 3-8 December | Joint Expert Committee on the Physically Handicapped Child, first session, Geneva |
| 17-18 December tentatively | WHO Consultant Group on Medical Aspects of Social Security, Geneva |

**1952**

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| 7 January | WHO Executive Board : Standing Committee on Administration and Finance, Geneva |
| 7-12 January | WHO Expert Committee on Drugs Liable to Produce Addiction, third session, Geneva |
| 22 January | WHO Executive Board, ninth session, Geneva |

# REGIONAL ORGANIZATION FOR AFRICA

The last stage in the regionalization of WHO has been reached with the formation of a regional organization for Africa. Thus organizations have been established for the six regions demarcated by the First World Health Assembly : [1] the Eastern Mediterranean, South-East Asia, the Americas, the Western Pacific,[2] Europe,[3] and now, Africa.

The WHO Regional Organization for Africa formally came into being at the first session of the Regional Committee for Africa, held in Geneva from 24 to 26 September 1951 and attended by representatives of all the countries constituting the Region. Dr. J. N. Togba, of Liberia, was elected Chairman, and Médecin-Colonel G. Garcin, of France, Vice-Chairman. Professor F. J. C. Cambournac, of Portugal, served as Rapporteur. The meeting was devoted largely to administrative and organizational questions, including the selection of a site for the Regional Office and the nomination of a Regional Director.

Several places were proposed as possible sites for the Regional Office : Brazzaville (French Equatorial Africa), Kampala (Uganda), Monrovia (Liberia), and Santa Isabel (island of Fernando Po). Brazzaville was selected.

Dr. F. Daubenton, who has held the post of Chief of the WHO Office for Africa since 1950, was named Regional Director, subject to approval by the Executive Board. Dr. Daubenton has had considerable experience in public health and administration in South Africa, the Netherlands, and Indonesia. He was formerly one of the consulting medical officers for the Witwatersrand Gold Mines, Union of South Africa, and Director-General of the Medical Services of the Royal Netherlands Army. In 1948, he served as head of the WHO mission to Ethiopia ; in 1949, he was consultant in public-health administration for WHO in the Eastern Mediterranean Region, particularly in Libya and Eritrea.

In the course of the meetings of the Regional Committee, Dr. Daubenton spoke of the tremendous health needs of the African continent. He expressed the hope that the establishment of a permanent Regional Office in Africa would, in co-operation with the governments concerned, facilitate giving adequate WHO assistance to the countries requesting it, and he outlined the help which had already been given in the past year—in sanitary engineering, public-health administration, nutrition (in collaboration with FAO), control of malaria and bilharziasis, and the award of fellowships. General programmes for the Region for 1952 and 1953, which were drawn up by the Regional Committee, are to continue operations along these same

[1] *Chron. World Hlth Org.* 1948, 2, 191
[2] See page 319.
[3] See page 312.

lines. Emphasis will be laid on the training of medical and auxiliary personnel, one of the major concerns in Africa.

The next meeting of the Regional Committee for Africa will be held in Monrovia, Liberia, in August 1952.

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## REGIONAL ORGANIZATION FOR EUROPE

The Regional Organization for Europe, which was to be established as soon as a majority of the countries concerned expressed their willingness, was constituted during the second session of the Consultative Committee for Europe, in accordance with the vote of representatives of 16 European countries, who met in Geneva from 3 to 5 September 1951. Following this decision, the Consultative Committee became the WHO Regional Committee for Europe.

The Regional Office will be set up for the time being at WHO Headquarters in Geneva. Dr. N. D. Begg was nominated Regional Director for Europe, subject to approval by the Executive Board. Dr. Begg is a specialist in public health. He was Medical Superintendent of the Eastern Communicable Diseases Hospital, London, and later Chief Medical Officer for UNRRA in Poland. He headed the WHO mission in the latter country before being appointed Chief of the WHO Special Office for Europe on its establishment on 1 January 1949.

### Programme Studied

*General principles*

The Regional Committee examined the budget and programmes proposed for 1952 and 1953, which will be financed by WHO, UNICEF, and the programme of technical assistance for economic development. During the preceding session the Consultative Committee had laid down some guiding principles for the work of the Organization in Europe for the next four years. In the opinion of the committee, programmes in such a technically advanced region as Europe should aim less at demonstrating individual disease-control methods than at assisting governments in co-ordinating existing health policies, exchanging experience on common health problems, and intensifying the training of all grades of public-health personnel. WHO, it is felt, would best help governments to strengthen their national health-services by these methods and would thus ensure the most fruitful results for technical assistance in Europe.

In addition, since numerous problems are common to several countries, it is possible to organize—in the highly developed centres of a variety of host countries—symposia, seminars, or training courses from which all would benefit, including some countries outside the European Region. It is intended to use a considerable portion of the funds available for fellowships for short-term awards to participants in such courses or symposia.

*Specific projects*

In addition to assisting national training institutes, particularly public-health schools, by providing consultants and lecturers of international reputation and by supplying teaching materials, the general programme of the Regional Organization for Europe includes a number of activities of a regional character involving many countries. For example, in agreement with the Governments of Denmark, Finland, Norway, and Sweden, a three-month course in tuberculosis control is being given in 1951 and will be repeated in the following years. Another joint effort is the establishment of a venereal-disease-demonstration project in the maritime and fluvial port of Rotterdam, beginning in 1951. It is intended that this city should become a centre for the study of venereal-disease-control problems of international importance. Courses will be instituted there, with WHO assistance.

During 1952 it is planned to organize a seminar on zoonoses, in connexion with the course in the laboratory diagnosis of rabies which is being considered for the Eastern Mediterranean Region. This seminar will be devoted to brucellosis, Q fever, and bovine tuberculosis. In 1953 a seminar along similar lines, dealing with hydatidosis, tularaemia, leptospirosis, and meat hygiene, might be organized in Spain or in Yugoslavia.

A demonstration and training centre for rural public-health problems has been inaugurated at Soissons, France, and will provide training facilities in the future to participants from other European countries. This centre was organized by the French Government in co-operation with the International Children's Centre, the Rockefeller Foundation, UNICEF, and WHO.

In 1953 it is planned to organize a seminar to discuss progress achieved and problems encountered in applying the new *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death.* Comparison of experience gained in different countries will certainly be extremely valuable. Some countries in Europe are paying increasing attention to vital and health statistics, organizing basic services for this purpose, or concentrating on specialized fields such as hospital, morbidity, or cancer statistics. In 1951 a course was given in Geneva for coders responsible for applying, at a national level, the Sixth Revision of the International Lists of Diseases and Causes of Death.[1]

[1] *Chron. World Hlth Org.* 1951, 5, 275

The anaesthesiology training centre in Copenhagen, inaugurated in May 1950,[2] will continue its activities with the assistance of WHO. It is probable that after the 1953 course the University of Copenhagen will take over complete responsibility.

Other projects concern : the annual seminar for European sanitary engineers ; [3] the training of specialists in research on, and the production of, antibiotics at the Istituto Superiore de Sanità, Rome ; [4] the co-ordination of health services for seafarers, which so far have been developed independently, and sometimes along different lines, in various countries ; the rehabilitation of refugees whose health is impaired, particularly those suffering from tuberculosis ; the care of physically handicapped children ; training courses or symposia ; and discussions on a variety of problems related to mental health, such as the seminar on alcoholism in Copenhagen in 1951 and a seminar on the psychiatric problems of childhood which will take place in Oslo in 1952.

[2] *Chron. World Hlth Org.* 1950, **4**, 191
[3] *Chron. World Hlth Org.* 1951, **5**, 81
[4] *Chron. World Hlth Org.* 1951, **5**, 274

## REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

### Fourth Session

The fourth session of the WHO Regional Committee for South-East Asia was held in Rangoon, Burma, from 20 to 25 September 1951. It was attended by delegations from Afghanistan, Burma, Ceylon, France (for French India), India, Indonesia, Portugal (for Portuguese India), and Thailand. Also present were observers from the Economic Commission for Asia and the Far East (ECAFE), UNICEF, and FAO, and invitees from the Economic Co-operation Administration (ECA) and the Burmese Red Cross. The committee elected Dr. Svasti Daengsvang, of Thailand, as Chairman and Dr. A. L. de Sousa Sabrinho, of Portuguese India, as Vice-Chairman.

At the opening session, attended by more than 100 guests from government and other services in Rangoon, addresses of welcome were delivered by Daw Khin Kyi (Mrs. Aung San), the retiring Chairman, and by U Khin Maung Lat, Minister for Social Services of the Union of Burma. The representative of the ECAFE conveyed to the meeting the good wishes of Mr. Trygve Lie, Secretary-General of the United Nations, and of Dr. Lokanathan, Executive Secretary of the ECAFE.

Noteworthy during the five-day session was the freedom with which the viewpoints of different countries were presented and discussed. As the

Chairman commented in his closing address, " We have been able to plan more boldly than in previous years, and this planning in common has helped us all to understand each other's difficulties and problems."

This year the Regional Director's report was discussed country by country and item by item. Among the points made were that the main

**FIG. 1. SOUTH-EAST ASIA REGIONAL COMMITTEE — I**

Dr. Svasti Daengsvang, Chairman, addresses one of the sessions.
Right, Dr. C. Mani, Regional Director

criterion for giving international assistance should be the capacity of recipient countries to absorb the aid given, and that local experts should co-operate more closely in detailed planning of internationally aided projects. Delegates expressed concern about the increasing difficulties in obtaining supplies of DDT and other products essential for health projects, and criticism was voiced of the policies restricting the amounts of supplies and equipment which WHO can provide in addition to its advisory and demonstration services.

### Co-ordination of Programmes

The committee gave considerable attention to the pressing need for co-ordination of the health programmes now being launched in many countries of the Region with the assistance of different bodies such as ECA, the Colombo Plan, and various United Nations specialized agencies. It was learned that co-ordinating committees, working at the national level, had already been formed in Burma, Indonesia, and Thailand, and that WHO

public-health advisers working with the governments of Burma, Afghanistan, and, possibly, Thailand would assist local health directorates in coping with the enormous amount of planning and co-ordination which they had rather suddenly been asked to undertake.

### Endorsement of Programmes

By far the most important part of the committtee's work was the endorsement of the WHO programmes and budgets for the Region,

**FIG. 2. SOUTH-EAST ASIA REGIONAL COMMITTEE — II**

The Programme Committee in session. Left to right : Mr. A. J. Joseph, Rapporteur ; Dr. Maung Gale, Chairman

involving an expenditure of $1,900,000 for 1952 and of over $2,000,000 for 1953. Detailed consideration was given to the proposals by a programme committee under the chairmanship of Dr. Maung Gale, of Burma. Mr. A. J. Joseph, of Ceylon, served as Rapporteur.

The proposals placed before the committee included WHO projects financed under United Nations technical assistance funds as well as those coming under WHO's regular budget. In a majority of cases it was assumed that certain quantities of supplies and equipment essential for getting the programmes under way would be forthcoming from UNICEF or other sources. These supplies amount to a little more than $2,000,000.

While there was little scope for changes in the proposals for 1952, which had already been endorsed along general lines at the regional committee meeting of the previous year, and which had been approved by the Fourth World Health Assembly, there was considerable modification of the 1953 programme proposals. Suggested changes entailed additional expenditure for projects in Burma, Ceylon, French India, and Thailand. The Regional Director stated that he hoped to be able to finance some of these additional projects from savings. For his guidance the committee established the following priorities : for Burma, a leprosy consultant and a second tuberculosis demonstration and training centre ; for Ceylon, consultants in medical supplies and in medico-legal work ; for French India, library books for the medical college ; and for Thailand, a thoracic surgery unit. Secondary priorities were also established for other additional requests, including teaching equipment, fellowships, expert consultants, and, for Ceylon, a leprosy-control team.

Emphasis in the 1952 and 1953 programmes will continue to be placed on increased training facilities for health workers and on strengthening teaching institutions for auxiliary medical personnel, especially for nurses, midwives, and sanitarians. As in 1951, a high priority will be given to the control of malaria, treponematoses, and tuberculosis (including BCG-vaccination campaigns), and to the promotion of nursing and maternal and child health activities, with particular emphasis on paediatrics. In addition to the continuation and expansion of existing activities in these fields, the following were approved : medical teaching missions for Burma and Ceylon ; an environmental sanitation project for Thailand ; advisory services in leprosy for Burma and Ceylon ; and, for India, assistance to the Indian Council of Medical Research in investigations on certain aspects of the epidemiology of plague and cholera, and expert advice on the critical problem of population control. Projects which aroused particular interest included those for joint WHO/UNICEF action to assist the Governments of India and Ceylon in establishing plants for the local production of DDT and to set up a penicillin-production factory in India.

### Maternal and Child Health Centre

During the session an informal meeting of public-health experts was held to discuss the syllabus of the enlarged maternal and child health centre to be opened next year in connexion with the All-India Institute of Hygiene and Public Health in Calcutta. The new centre is estimated to cost $2,000,000, the expense to be shared in approximately equal parts by the Government of India and UNICEF. Dr. C. K. Lakshmanan, Director of the Institute, explained that the new centre will involve reorganization and expansion of an existing rural training field, the establishment of a new urban training field, and construction of new hostel accommodations

for students. Allied sections of the Institute to be equipped under the expansion programme to serve the Department of Maternity and Child Health include those dealing with (1) biochemistry and nutrition, (2) sanitary engineering (for environmental sanitation), (3) public-health administration, (4) epidemiology, (5) statistics, and (6) microbiology.

According to Dr. Lakshmanan, the Indian Government has undertaken to continue the centre, after an initial period of five years, as an integral part of the Institute, without further assistance from UNICEF. The Government will, in addition, provide instruction free of charge to 250 students from outside India, for a period of one academic year in each case, in return for the support given by UNICEF and as a matter of international co-operation. When in full operation, the centre is expected to train 60 students per year.

It was recommended that the syllabus of the new centre include (1) a postgraduate course in maternal and child health for doctors, (2) a public-health nursing course for certified nurses, and (3) a short-term course for junior health workers. The centre will also provide facilities for holding seminars, demonstrations, and public discussions on child health and related problems for professional medical teaching staffs and hospital staffs.

**Other Decisions**

Reviewing the fellowships programme of WHO, the committee was in general agreement that, in spite of certain defects pointed out by the Regional Director, fellowships offered a valuable means of strengthening national health-services when there were not adequate facilities for advanced training in public health within each country.

Trachoma control was discussed, but the committee decided to await the results of certain experiments now being carried out on the efficacity of aureomycin ointment before endorsing concrete proposals for control projects.

Recognizing that environmental sanitation conditions in and around ports and airports should be improved in order to prevent the spread of quarantinable diseases, the committee recommended that all governments take urgent steps in port areas to prevent the breeding of rodents and insect vectors of disease, to ensure proper disposal of human waste, and to provide pure water-supplies and facilities for vaccination against communicable diseases.

When discussing long-term planning, the committee decided to continue its present, so-called " short-term ", programmes for the next few years. The necessity for first providing the basic health services around which various other health programmes might be developed was stressed. The establishment of at least one model rural health centre in each country was considered essential for demonstration purposes and for the training

of the required personnel. The need for making every country self-sufficient in vaccines and sera was recognized.

The Regional Committee for South-East Asia accepted the invitation of the Indonesian Government to hold next year's meeting in Indonesia.

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## REGIONAL COMMITTEE FOR THE WESTERN PACIFIC

### First Session

The establishment of a WHO regional organization for the Western Pacific was proposed at, and approved by, the Third World Health Assembly.[1] A temporary office for this region was subsequently set up in Hong Kong, and it was planned to hold the first meeting of a regional committee there in March 1951. Political developments in the area led the Executive Board, at its seventh session,[2] to postpone the meeting. However, the Fourth Health Assembly, acting on a request from the delegations of Cambodia, Korea, Laos, the Philippines, and Viet Nam, terminated the postponement and decided that the first session of the Regional Committee for the Western Pacific should be convened in Geneva in May 1951.[3] This first session was devoted principally to administrative and legal matters. The date for a second session was set, and the groundwork was laid for the establishment of a regional office and organization. The next step was the appointment of Dr. I. C. Fang as Regional Director for the Western Pacific and the designation of Manila, the Philippines, as the site of the Regional Office.[4]

### Second Session

The second session of the Regional Committee for the Western Pacific opened in Manila on 18 September 1951. Present were the Vice-President and Cabinet Secretaries of the Republic of the Philippines as well as representatives of Australia, Cambodia, China, France, Japan, Korea, Laos, the Netherlands, the Philippines, the United Kingdom, the USA, and Viet Nam. Delegates from Australia and the USA attended as observers only ; New Zealand and Portugal were not represented.

Following addresses of welcome, the committee, under the chairmanship of Dr. R. G. Padua, Under-Secretary of Health for the Philippines, elected two Rapporteurs : Dr. K. C. Yeo, of the United Kingdom, and Dr. Son Mam, Minister of Health of Cambodia. Dr. Phan Huy Dan, Chief Delegate for Viet Nam, served as Vice-Chairman.

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[1] *Chron. World Hlth Org.* 1950, **4**, 207
[2] *Chron. World Hlth Org.* 1951, **5**, 38
[3] *Chron. World Hlth Org.* 1951, **5**, 194
[4] *Chron. World Hlth Org.* 1951, **5**, 236

*Problem of supplies*

The question of supplies—one which engaged much of the attention of the committee, and the urgency of which was reflected in discussions during meetings held in the same month by committees of other regions—was introduced early in the session when delegates from Laos, the Philippines, and Viet Nam asked that modification of future programmes be considered to allow for the provision of supplies for health programmes, in addition to specialists requested from WHO. It was stated that in many countries in the Western Pacific Region, most of which are economically underdeveloped, governments find it extremely difficult, if not impossible, to supply equipment for internationally assisted health projects. Dr. Fang, pointing out that WHO is not a supply agency and that other organizations have been created for this purpose, emphasized that, in view of WHO's small budget, the provision of supplies was not possible. However, the discussions gave rise to two resolutions which were presented to, and passed by, the committee :

1. The Regional Director was requested to consult the UNICEF Regional Office for Asia with a view to joint consideration of the nature and extent of aid which might be given, in combined medical programmes, to Cambodia, Laos, and Viet Nam, due attention being paid to the current social and economic conditions as well as to the medical needs of these three countries.

2. WHO was requested to take steps to provide more material assistance, in the form of essential equipment and supplies for medical and public-health projects, so that many of the Member States of the Western Pacific Region might receive practical aid and deal with their medical and public-health problems more quickly and effectively.

*Plans approved*

With minor modifications, the proposed programme and budget of the Western Pacific Region for 1953 was approved. These plans include assistance to Brunei, Cambodia, China (Taiwan), Hong Kong, Japan, Korea, Laos, Malaya, New Zealand, North Borneo, the Philippines, Sarawak, Singapore, and Viet Nam, together with services to countries as yet undesignated.

The committee discussed ways and means of avoiding the confusion which sometimes results from having a number of international organizations interested in health work ; a resolution was passed recommending that all Member States establish single points of contact for effective liaison in matters of international health.

After approving the Regional Director's report, the committee adopted resolutions for (1) taking urgent steps to improve sanitary conditions in and around ports and airports ; (2) developing a five-year health pro-

gramme ; (3) studying the report of the Joint FAO/WHO Expert Committee on Nutrition ; [5] (4) assisting Member States in drawing up short- and long-term national health programmes ; (5) recognizing the need for an informed public opinion, especially in underdeveloped countries, with regard to the fundamental principles of self care and child care, as well as the need for persons trained in child care ; (6) ensuring the regional supply of insecticides essential for carrying out long-term malaria and insect-control projects ; (7) furthering public information activities within the Region ; (8) furnishing, by all Member States, of uniform national health reports for inclusion in WHO records ; and (9) maintaining the continuity of delegates to the World Health Assembly and the Regional Committee.

### Future Meetings

The holding of two seminars was announced : the first, on nursing, to take place in 1952 ; the second, on mental health, to be held in 1953. The delegate of China proposed Taipeh, Taiwan, for the nursing seminar ; and the delegate of Australia offered Sydney University as the meeting place for the mental health seminar. Both offers were accepted.

The third session of the Regional Committee for the Western Pacific will take place in Saigon in September 1952. Technical discussions will be held in conjunction with this session, the subject chosen being " Regional aspects of the education and training of public-health personnel ".

[5] *World Hlth Org. techn. Rep. Ser.* 1951, 44

## THE COST OF SICKNESS AND THE PRICE OF HEALTH

A study entitled " The cost of sickness and the price of health ", prepared by Professor C.-E. A. Winslow as a basis for the technical discussion on the economic value of preventive medicine which is to take place during the Fifth World Health Assembly, has just been published as No. 7 in the Monograph Series of the World Health Organization.[1]

### Cost of Sickness

The " relatively small investment " involved in a sound public-health programme is compared with the cost to the community of a low life-expectancy-rate and a high morbidity-rate. The economic burden of premature death and of physical and mental disability, with the loss of

[1] Winslow, C.-E. A. (1951) *The cost of sickness and the price of health*, Geneva (*World Health Organization : Monograph Series*, No. 7), 106 pages, price 7/6, $1.50, or Sw. fr. 6.00

productive power and expenditure of large sums on the care and treatment of the sick which they involve, is shown by illustration to exceed that of preventive health measures. In the period immediately preceding the second World War, in Germany, where male life-expectancy was 60 years, the average income per capita was $520 ; in Mexico, where male life-expectancy was 37 years, the average income per capita was only $61. A Swedish economist has demonstrated that illness costs Sweden the equivalent of $50 per capita per year. In Egypt, bilharziasis alone decreases the production of the country by 33%. Malaria causes a loss of man-power of 10%-15% of the total labour force of Southern Rhodesia. It has been estimated that the annual cost of temporary and permanent disability in the USA is between $3,000,000,000 and $4,000,000,000 (between 1% and 2% of the national income).

With the application of present-day scientific knowledge, disease can be prevented and controlled to an extent hitherto unforeseen. Improved environmental sanitation has led to a reduction in the incidence of intestinal diseases, such as typhoid fever, and mosquito-borne diseases, such as yellow fever and malaria. Data from campaigns on all continents of the world illustrate the successes which have been achieved by control programmes, and the comparatively low cost to the community of planned control activities as compared with that of the unchecked spread of disease. Before a recent sanitation programme carried out on the Amazonian watersheds of Peru, 99% of the schoolchildren in the area were infected with intestinal parasites ; four years later the percentage infected had fallen to 58%. In Greece, the incidence of malaria was reduced from at least 2,000,000 cases in 1942 to only 50,000 cases in 1949 ; it is estimated that 30,000,000-60,000,000 man-work-days a year have been saved as a result. Achievements in the control of contact-borne diseases, such as tuberculosis and the treponemal diseases, while less spectacular, may be almost equally effective. The joint WHO/UNICEF antiyaws campaign at present in operation in Haiti has already resulted, it is estimated, in the return to work of 100,000 incapacitated persons, with a consequent increase in national production of $5,000,000 a year.

It is not, however, sufficient to protect the community against specific communicable diseases. General health and well-being must also be promoted. Special categories of the community, such as mothers and children, must be specially cared for. Adequate nutrition, the relation of which to productive capacity has been revealed by many studies, must be provided. Atmospheric temperature, housing conditions, and conditions in industry, which also affect the health and efficiency of the individual, equally require supervision. Mental and nervous diseases constitute a grave economic burden, especially to industry ; and mental hygiene, which also forms an approach to the grave problems of alcoholism and drug addiction, merits an important place in the health programme.

## Cost of Health

While the diversity of pattern to be met with in national health services —differences in degree of autonomy within the national governmental organization, in the services covered, and in relations with local health services—is recognized as inevitable, some indication is given of the cost of planning any national health service, and of the needs it should meet.

The national health service should so plan activities that expenditure is concentrated to maximum advantage. It should afford inspiration and leadership to the local health services, and provide specialized technical assistance at the local level. Each local area should be provided with public-health personnel adequate for its needs. The all-important members of the public-health team—the administrator, the engineer, and the nurse—need the assistance of other specialists, such as the veterinarian and the dentist, and, of chief importance, the health educator, the essential link between the health team and the general public. The almost universal shortage of personnel can be countered only by the provision of more training facilities and of better organized recruitment. Institutional facilities, such as hospitals and clinics, which are also inadequate in many areas, must be used to the best advantage.

While the cost of public-health programmes will obviously differ according to the differing needs of nations, and to the balance maintained between expenditure on curative and on preventive health services, respectively, some idea of an " ideal " programme may be obtained from a study of existing programmes. It has been estimated that in the more prosperous areas of the world a purely preventive programme can be financed at a cost of about 0.5% of the national income, while curative medicine requires an expenditure ten times as great. In Great Britain, for the year 1949/50, expenditure on the all-inclusive National Health Service was more than six times as great as the expenditure on purely preventive services. WHO could contribute to the development of sound and economically possible programmes by collecting and analysing data on the general patterns of existing national health services, on administrative organization in local areas, on numbers and future needs of public-health personnel, and on the cost of both actual and conjectural health programmes.

## Relation of Health to Social and Economic Development : Technical Assistance

The poverty resultant upon disease has been amply illustrated. Data from even highly prosperous countries show that, conversely, poverty is an important causative factor of disease. Some theorists believe that drastic limitations on population offer the " only possible solution " to the problem of poverty, but improved health, and the economic develop-

ment consequent upon it, is a more humane and less controversial solution. As the standard of health in a community is intimately related to the economic and social conditions prevailing therein, health programmes cannot be planned independently, but must be integrated with programmes for economic and social improvement. The success of such programmes leads to the added prosperity which in turn leads to improved health.

The expenditure involved in economic and social improvement is too great to be supported unaided by the underdeveloped countries. Realization of this fact has led to the formulation of a worldwide programme of co-operative assistance, a programme which, to the historian of the future, " may well seem . . . one of the most brilliant and outstanding contributions of the 20th century to world history ".

The Pan American Sanitary Bureau, the Rockefeller Foundation, and the League of Nations, among others, were pioneers in the provision of measures of technical assistance to various regions of the world, but with the development of the United Nations expanded programme of technical assistance for the economic development of underdeveloped countries, the technical assistance programme has been placed on a formal international footing. The health administrator, and WHO as the co-ordinating authority on international health work, have a major part to play in solving the administrative and other problems of technical assistance, and in realizing its great potentialities. " Technical assistance is not a relief project for feeding starving millions ; nor is it a vision of a new world which would reorganize national economy overnight and impose upon primitive peoples an alien way of life. It is a direct, simple, practical procedure for providing the leadership of trained technical personnel to assist underprivileged peoples in improving their own standard of living in their own way . . . with major possibilities of improvement in total world economy as a result. In such a programme as this is to be found the basis for the future health of the world."

## MALARIA IN EQUATORIAL AFRICA

In a previous number of the *Chronicle* [1] mention has been made of the Malaria Conference in Equatorial Africa which was held at Kampala, Uganda, in November and December 1950, and the report on which was published as No. 38 in the *World Health Organization : Technical Report Series*. The discussions at this conference, and the conclusions it reached, were based on a number of studies carried out in different parts of Africa.

[1] *Chron. World Hlth Org.* 1951, **5**, 95

A selection of the papers presented has recently been published in a number of the *Bulletin of the World Health Organization*.[2]

In this series of articles various aspects of the problem of malaria in Africa are considered. Dr. Leonard J. Bruce-Chwatt, of the Malaria Service, Medical Department, Nigeria, has summarized data obtained from various surveys of malaria mortality-rates, incidence, and distribution in Nigeria. The malaria survey of South-West Africa was undertaken by Dr. Botha De Meillon, entomologist at the South African Institute for Medical Research, Johannesburg, at the invitation of the Administration of South-West Africa.

In another important study, Dr. De Meillon enumerates the species and varieties of malaria vectors in Africa, and describes their geographical distribution and bionomics. M. H. Holstein, Chef du Laboratoire d'Entomologie, Service général d'Hygiène mobile et de Prophylaxie de l'Afrique-Occidentale Française, discusses the anopheles of French West Africa and reviews the epidemiology of malaria there. A campaign to eliminate the disease in Mauritius is described by Dr. M. A. C. Dowling, Officer in Charge of the Malaria Eradication Scheme at Floreal, Mauritius. Finally, a short paper by Mr. G. Davidson, of Colonial Insecticide Research, Taveta, Kenya, reports the results of the use of DDT and BHC in malaria control at Taveta.

These articles are briefly summarized below.

*Malaria in Nigeria* [3]

Surveys over the past 20 years have revealed that the whole of Nigeria is malarious, while several regions are hyperendemic. The malaria transmission period varies from less than 5 months a year in the Sudan and Sahel savannah regions to almost 12 months of the year in the coastal belt. While eight species of anopheline vectors have been found, *Anopheles funestus* and the *A. gambiae* group are the most important. *A. gambiae gambiae*, which breeds relatively indiscriminately, is found throughout Nigeria, while *A. funestus* is found only near clean, more or less shaded, water. The seasonal prevalence of the two vectors varies considerably ; nevertheless, it may be said that while *A. gambiae gambiae* is the wet season vector, *A. funestus* becomes the chief vector during the first half of the dry season.

Malaria morbidity and mortality data are presented separately for the small non-African population, on the one hand, and the very large indigenous population on the other. The total number of malaria cases among the indigenous population has increased from 84,401 in 1944 to 123,265 in 1948, while the case fatality-rate per 1,000 cases has increased from 1.56 to 1.95 over the same period. These figures cannot, however, be considered

[2] *Bull. World Hlth Org.* 1951, **4**, No. 3

[3] Article in English with summary in English and French

absolutely reliable, as annual returns are based solely on attendance figures at the 75 government and native administration hospitals, exclusive of attendance figures at the 526 native administration dispensaries, and, even in the hospitals, malaria diagnosis is often based purely upon an individual interpretation of clinical symptoms without confirmation by laboratory examination.

No country-wide antimalaria programmes are in operation in Nigeria at present. However, a ten-year malaria-control scheme was inaugurated in 1948 when a special Malaria Service for Nigeria was established, with the Director of the Medical Services in charge. Meanwhile, mosquito-control schemes have been introduced in some regions. In the period 1942-7, 6 square miles (15.5 km²) of tidal swamps breeding huge numbers of mosquitos were reclaimed in the urban district of Lagos through the Lagos Mosquito-Control Scheme. A pilot project—the Ilaro Experimental Anopheles Eradication Scheme—for anopheles eradication was instituted in the town of Ilaro in 1950 by the Malaria Service. The Cameroons Development Corporation has organized a mosquito-control scheme in the Tiko and Bota areas.

As regards treatment and prophylaxis, while there is no standardized treatment schedule for malaria in Nigeria, quinine, mepacrine, and proguanil are in general use, and antimalarial drugs are taken regularly by many educated Africans, as well as by nearly all non-African residents.

*Malaria survey of South-West Africa* [4]

The climate of South-West Africa is of the desert type, that is, hot days followed by very cold nights. The cold Benguela current flowing up the west coast plays an important part in determining the climate. This climate undoubtedly has an influence on malaria endemicity and is thought to play some part in several instances of " anophelism without malaria " encountered.

The presumed vectors are *Anopheles gambiae* over the whole territory plus *A. funestus* on the Okavango and probably the Kunene. Sufficient dissections could not be undertaken to confirm this definitely. The possible role of *A. listeri* as a vector was not settled. The distribution of *gambiae* is shown on a map.

The bionomics and relation to malaria of *A. gambiae*, *A. funestus*, and *A. listeri* are dealt with in some detail.

The endemicity of the disease was estimated from spleen- and parasite-rates of different age-groups of indigenous native people. The varying degrees of endemicity are classified according to Wilson's four groups. Malaria of the highest endemicity (Wilson's Group I) occurs along the Okavango River and probably on the Kunene and its immediate environs.

[4] Article in English with summary in English and French

From there south the degree of endemicity gradually decreases and most of the country south of latitude 19° south falls into Wilson's lowest group. This large area is subject to either localized or widespread epidemics. A map is produced to show the approximate areas of endemicity.

*Plasmodium falciparum* accounts for 91% of malaria in the areas surveyed. *P. malariae* and *P. vivax* make up the rest in approximately equal proportions.

Control and eradication of vectors is not dealt with exhaustively, but it is felt that eradication of *A. gambiae* from the greater part of South-West Africa does not present insuperable difficulties. Control by means of residual insecticides offers the best hope for the highly endemic regions on the Okavango and in Ovamboland.

*Species and varieties of malaria vectors in Africa, and their bionomics* [5]

The African vectors may be divided into three groups : primary, secondary, and tertiary. The first group—*Anopheles gambiae gambiae, funestus funestus* (and *funestus* var. *imerinensis* (Madagascar only))—are the principal vectors over the greater part of Africa south of the Sahara, including the islands of the region. Largely endophilic, they are vectors wherever they are found. Both vectors may be responsible for intense endemic malaria, while *gambiae* is the most important vector of epidemic malaria. The behaviour of both *funestus* and *gambiae* is not uniform in all localities. While it is without doubt influenced by climatic factors, biological races within the species may also exist.

The second group—*brunnipes* (Leopoldville), *gambiae* var. *melas* (French Guinea, Gold Coast, Ivory Coast, Nigeria, Sierra Leone), *hancocki* (Belgian Congo, Nigeria, Uganda), *hargreavesi* (Southern Nigeria), *moucheti moucheti* (Belgian Congo, Uganda,) *nili* (Belgian Congo, Nigeria, Sierra Leone), *pharoensis* (French West Africa), and *rufipes* (French West Africa, ? Sudan) —is of importance in the spread of malaria only in some restricted localities where the primary vectors are absent or rare. Elsewhere they are harmless and mainly exophilic.

The third group, primarily exophilic and suspected of being short-lived, are unimportant as malaria vectors.

Malaria control in the region depends upon control of the primary vectors, and of the secondary vectors when the primary vectors are absent or rare.

*Note on the epidemiology of malaria in French West Africa* [6]

Up to the present, about thirty anopheline species have been found in French West Africa. The author gives a list of them, followed by remarks

[5] Article in English with summary in English and French
[6] Article in French with summary in French and English

concerning the distribution of the most interesting species. The malaria vectors are classified in three categories : principal, secondary, and accessory vectors. *A. gambiae*, *A. funestus*, and *A. rufipes* are the principal vectors. *A. rufipes* plays a much more important role than was supposed, mainly because of its high sporozoite-rate. Various factors, such as the diversity of the breeding-places of this mosquito, its exophilism, and its flight range, contribute to the difficulties of control and eradication. *A. gambiae* and *A. funestus* are two vectors of equal importance. According to the region and locality, sometimes *A. gambiae* predominates throughout the whole year, sometimes *A. funestus*, but there is more often an alternation of the two species according to season, *A. gambiae* predominating during the rainy months, when its development is favoured by the rains, and *A. funestus* during the dry season.

*An experiment in the eradication of malaria in Mauritius* [7]

*Anopheles* mosquitos were imported into Mauritius about 1860, and the first severe malaria epidemic took place in 1867, when the death-rate rose to 120 per thousand.

Owing to the antimalarial programme which was reorganized in 1945-6, the central plateau and the town of Port Louis were relatively free from malaria by 1948. Most of the remainder of the island, however, still presented a high incidence of malaria.

In November 1948 a research team, sponsored by the Government of Mauritius in conjunction with the British Colonial Insecticides Committee, started to organize an experiment on the elimination of malaria.

The basis of this campaign was the indoor spraying of every building so that all walls and ceilings should be covered with a lethal dose of insecticide. A preliminary survey had been made, and records were kept of every building treated.

A careful check on the mosquito population was maintained throughout the campaign. Catches were made in 7,767 houses before, and 76,246 houses after, spraying. The percentage reduction in numbers of mosquitos per house was 97.1 for *Anopheles gambiae* and 99.9 for *A. funestus* and *Aëdes aegypti*. *A. funestus*, originally the more formidable malaria vector in Mauritius, and *Aëdes aegypti* have been virtually eliminated. *A. gambiae*, on the other hand, has been found breeding throughout the coastal zone in March and April and still enters new, unsprayed buildings in large numbers. For this reason it was decided to initiate a further experiment on eradication of *A. gambiae*, by larvicidal methods, in the district of Flacq. All sluggish and stagnant water would be treated during the dry season with a DDT solution in high-spread malariol, three times at fortnightly intervals, and spot-oiling used subsequently during routine checks for water-surfaces remaining positive.

[7] Article in English with summary in English and French

Malariometric data were collected during three surveys of representative children up to 15 years : (*a*) when the team arrived in 1948, (*b*) after the initial spraying campaign in 1949, (*c*) in 1950. The results obtained in the third survey compared with the first show reduction in spleen-rate (from 34.8 to 2.8), in parasite-rate (from 9.5 to 0.36), in spleen size, in parasite intensity, and in proportion of *Plasmodium falciparum*. The average parasite-rate among children born after the first spraying in their locality was 0.27.

Malaria morbidity figures also show an encouraging diminution. The number of cases notified by hospitals and dispensaries during the seasonal months of January-June 1950 show a reduction of 86.0% over the previous record year of 1948. Many of the notified cases were probably not malaria, since of 1,760 examined bloodslides only 3.0% showed malaria parasites. Total death-rates and infant mortality-rates have also fallen considerably since 1934-48, and malaria death-rates per 10,000 population for the epidemic first six months of the year have declined from a mean rate of $32.2 \pm 8.07$ for 1934-48 to rates of 12.9 in 1949 and 4.9 in 1950.

*DDT and BHC in adult mosquito control* [8]

In an investigation into the use of DDT and BHC against adult mosquitos at Taveta, Kenya, four experimental huts were constructed and treated with Gammexane (BHC) or with DDT in various forms.

In the first month after spraying, most of the mosquitos in the BHC-treated hut were found dead on the floor each morning ; the rest died within a few hours of capture. An appreciable 24-hour mortality among the mosquitos continued in later months, and even after six months mosquitos applied to wall surfaces for one hour under Petri dishes nearly all died within 24 hours.

In the DDT-treated huts most of the mosquitos collected each morning were in the window traps, 80% or more dying within 24 hours. DDT wettable powder ' Ditrene ' proved to be a less efficient killer than DDT oil-bound suspension.

Laboratory experiments showed that neither of the insecticides exercised a repellent effect, but that the contact-time before irritation and flying were induced was shorter in the case of DDT than in the case of BHC, and this time was not sufficient for DDT to produce a significant kill among female *A. gambiae*.

[8] Article in English with summary in English and French

# INFLUENZA IN 1950-1

The influenza epidemic which broke out throughout the world, particularly in Europe, during the winter of 1950-1 was much less severe than that of 1948-9. This is the clear conclusion which follows from the morbidity and mortality statistics which have just been published, analysed, and commented upon by Dr. M. J. Freyche, Chief of the Epidemiological Information Section, WHO, and Dr. C. Klimt, of the Co-ordination of Research Section, WHO, in the *Epidemiological and Vital Statistics Report*.[1] This conclusion confirms the preliminary information received by WHO during the epidemic and summarized in a previous issue of the *Chronicle*.[2] The trend of the epidemic in various countries, as shown by the morbidity curves for the period October 1950 to April 1951, is indicated in fig. 3.

*Europe*

Although mild in most countries throughout the world, the 1950-1 influenza epidemic nevertheless took a rather serious form in the United Kingdom, which had been relatively little affected by the 1948-9 outbreak. In 126 large towns of England and Wales, the number of deaths per period of four weeks from 5 November 1950 to 24 March 1951 was, successively, 88, 223, 3,682, 2,946, and 465 (see fig. 4). During the second week of January, the number of deaths from influenza at Liverpool amounted to 216, as compared with a weekly maximum of 230 in 1918. The general mortality-rate (calculated per thousand inhabitants and per year) in these 126 towns during the week from 6 to 13 January was 25.6 (London, 20.5; Liverpool, 61.7). Fatal cases occurred especially among persons more than 55 years of age.

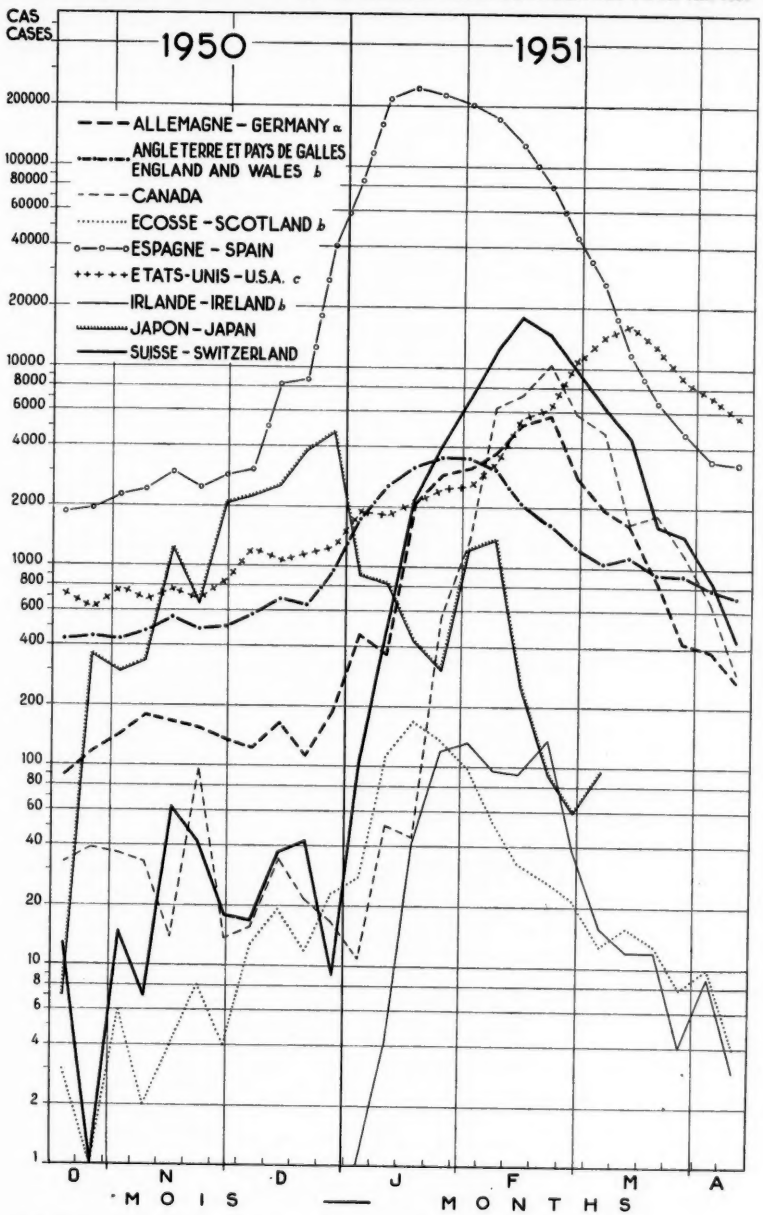
In Denmark, 90% absences were registered in numerous schools and factories at the peak of the epidemic. In France, some schools were closed. From an initial focus in San Sebastian, the epidemic spread throughout Spain, where the number of cases reported reached nearly 250,000 during the third week of January. In Switzerland, notifications rose from 108 during the first week of January to 18,100 during the week from 11 to 17 February. In Italy, the main spread of the epidemic occurred in February, during which month 10,300 cases were notified.

*Africa*

In the Union of South Africa, there was an epidemic lasting from the second week in May until September, with two successive outbreaks, one due to virus B and the other to virus A′. In Madagascar, incidence was highest in June and July, with nearly 12,000 notifications in each of these

[1] *Epidem. vital Statist. Rep.* 1951, **4**, 141
[2] *Chron. World Hlth Org.* 1951, **5**, 51

FIG. 3. INFLUENZA CASES REPORTED WEEKLY FROM OCTOBER 1950 TO APRIL 1951




[a] Germany : excluding the "Länder" Baden, Bremen and Hamburg

[b] England and Wales : cases of influenzal or primary pneumonia ; Scotland and Ireland : cases of influenzal pneumonia

[c] United States of America : excluding Texas

months. The morbidity recorded was higher than during any of the three preceding years.

In Egypt, the number of notifications from the end of December exceeded that in the corresponding weeks of each of the three preceding years. In Algeria, the epidemic, although very wide-spread, remained mild in nature.

*America*

In Brazil, the epidemic caused 79 deaths in Rio de Janeiro during the last week of December and the first week of January ; during the same period the number of deaths from pneumonia reached 176.

In Peru, there was no definite epidemic. In Bolivia, only sporadic cases were noted. The position remained normal in the following countries and territories : Argentina, Cuba, Curaçao, French Guiana, Haiti, Honduras, Nicaragua, Panama, Puerto Rico, Surinam (Dutch Guiana), Trinidad and Tobago, Uruguay, and Venezuela.

The first isolation of influenza virus during the winter 1950-1 in the United States of America was reported from Pittsburgh, at the end of December. The disease was prevalent throughout the country in a mild form ; at the end of March it had lost its epidemic nature. Virus A′ was isolated from 79 samples and a C-type virus (Francis) was isolated on one occasion in Michigan.

In certain parts of Greenland, nine-tenths of the population were affected by the middle of January.

*Asia*

In India, there was a slight epidemic of a mild nature in Madras in May and June 1950. A more serious outbreak was noted from July to September at the southern frontier of the State of Mysore ; more than 4,500 patients were hospitalized in two cities during this period as against 1,000 in June and 900 in October.

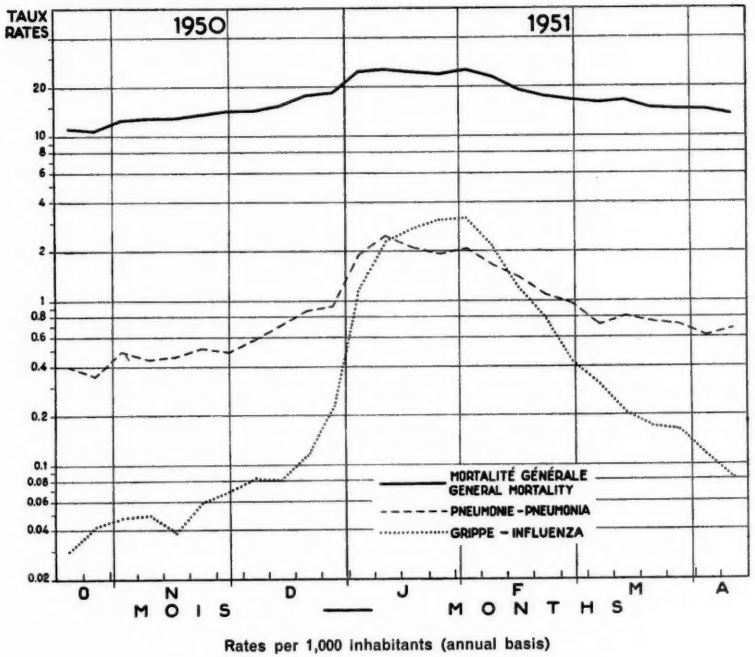
In Japan, where the disease had already been prevalent during the winter of 1949-50, the epidemic commenced in mid-October—i.e., nearly six weeks earlier than the preceding one—in the south of the country. By the middle of December it had reached the island of Hokkaido in the north, where during the last week of the month the number of cases exceeded that for the rest of the country. In all, nearly 21,000 cases were reported in 1950-1 as against 17,000 during the preceding winter.

In Iran, mild respiratory complaints of an influenzal type were reported ; by the beginning of January the epidemic was considered as at an end.

*Oceania*

The first cases were observed in the Cook Islands in May 1950. The disease spread rapidly throughout the archipelago, and the epidemic finished at the end of January. Adults between the ages of 30 and 49 were

FIG. 4. GENERAL DEATH-RATE, DEATH-RATE FROM PNEUMONIA AND FROM INFLUENZA IN 126 ENGLISH TOWNS, OCTOBER 1950 TO APRIL 1951




Rates per 1,000 inhabitants (annual basis)

severely affected by the disease ; jaundice was observed in almost all fatal cases.

In New Caledonia, a mild epidemic affected almost all the inhabitants in certain regions, above all during August and September. In the Tonga Islands, no cases were notified in October, but the number of notifications rose to 6,203 in December, falling to 14 in January. In Samoa, the epidemic, although short-lived, caused some schools to be closed ; young adults were the most seriously affected. In Tahiti, influenza caused some deaths ; it also appeared in the New Hebrides and in the Gilbert and Ellice Islands.

* * *

The authors of the article conclude with these words :

" The epidemic ... also put the WHO system of epidemiological supervision and information to the test. We hope that, thanks to the co-operation of a large number of voluntary reporters ..., and thanks to the reports regularly received from national health administrations, the World Influenza Centre, in London, the WHO Influenza Centres set up in some 40 countries and the Organization's regional offices, the information

transmitted by radio, by cable, or by means of the *Weekly Epidemiological Record* has proved to be of some usefulness.

" Influenza in 1950/51 fortunately remained mild. It nevertheless provided a valuable test, which enabled us to remove certain defects in the above-mentioned information system and to improve it so as to deal with possible outbreaks of a more serious character."

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# *Notes and News*

## Health Survey in Iraq

A survey of health conditions in rural Iraq has been undertaken by WHO, at the request of the Government of Iraq, under provisions for technical assistance for the economic development of that country. Dr. W. E. Holmes has accepted a four-month assignment with WHO in order to conduct this survey, which is being made in preparation for the establishment of a rural health demonstration centre.

Dr. Holmes has had considerable experience in rural health in the tropics. Following training in medicine, surgery, and public health at the University of Dublin, Ireland, and in tropical medicine and hygiene at the University of Liverpool, the United Kingdom, he spent many years in public-health service in Malaya.

## Serology Conference in India

A conference of serologists from South-East Asia was held under WHO auspices from 21 to 23 November 1951 at New Delhi, India. Following reports on the state of serology in various countries in the Region, lectures on technical aspects of serological testing were given by Dr. P. Krag, of the Venereal-disease Section at WHO Headquarters; Dr. E. Schmidt, of Ceylon ; Dr. K. V. Venkatraman, serologist to the Government of India ; and Dr. H. Y. Li, WHO serologist in Indonesia. Dr. J. Kvittingen, who has worked with the WHO venereal-disease-control team in India for more than two years, discussed mass serological testing in syphilis-control programmes and demonstrated blood-sampling and screening procedures. Two working groups were formed, one to study personnel and equipment problems, another to deal with test reagents and methods.

The conference was organized by the WHO Regional Office for South-East Asia. Fellowships were granted for serologists from Afghanistan, Burma, Ceylon, Indonesia, and Thailand to attend, and participation of others from the Western Pacific Region was invited.

## Nutrition Specialist Sent to Ceylon

A hospital dietitian from the United Kingdom, Miss Barbara Taylor, has been sent to Ceylon on a one-year assignment under the WHO technical assistance programme. She will study the diet problems in hospitals and similar institutions, advise and assist the Government of Ceylon in organizing scientific diet services, and plan and direct training courses in dietetics for hospital stewardesses and other personnel. Miss Taylor is well equipped for her task : in addition to being a trained nurse as well as a dietitian, she has had four and a half years' experience as hospital dietitian in New Delhi, India, and is therefore familiar with cooking and diet practices in the Far East.

## Tuberculosis

*Antituberculosis centre opened in Thailand*

An international centre for teaching and demonstrating all aspects of tuberculosis control has been opened in Bangkok, Thailand, with the assistance of UNICEF and WHO. This centre, equipped with modern laboratory, x-ray, and vaccination facilities, is one of several antituberculosis centres established, or about to be established, under UNICEF and WHO auspices in various parts of the world—in Burma, Egypt, El Salvador, India, Pakistan, Paraguay, and Turkey.

Dr. M. Mistral, tuberculosis specialist from Geneva, Switzerland, has recently joined the international team already at work at the centre. Other members of the staff include Mr. W. Williams (United Kingdom), x-ray technician ; Dr. C. Vijil y Tardon (Chile), epidemiologist ; and Miss C. Eriksen (Canada), public-health nurse.

**FIG. 5. TUBERCULOSIS CENTRE**

**Home-visiting, one of the activities of the WHO/UNICEF tuberculosis centres in India, forms part of the training of this WHO Fellow from Ceylon**

*Appointments at Office for the Americas*

Dr. J. A. Higgins (Ecuador) has been appointed Acting Regional Tuberculosis Adviser for the WHO Regional Office for the Americas, replacing Dr. I. M. Lourie, who is on leave of absence to pursue studies in public health. Before joining WHO, Dr. Higgins was Chief of the National Tuberculosis Service of Ecuador and past President of the Latin-American Union of Tuberculosis Societies.

Dr. K. B. Osvik (Norway) also entered the Tuberculosis Section of the Office for the Americas. As BCG Project Adviser he will be sent from country to country to aid in the development of BCG programmes. Dr. Osvik was formerly Chief of Mission for the Joint Enterprise in Ecuador, where, in conjunction with Dr. Higgins, he was responsible

for the development of a plan for testing almost 1,000,000 persons in a period of one year and vaccinating the non-reactors among them.

*Tuberculosis centre in India*

It has been reported that the number of persons attending the antituberculosis centre at Trivandrum, India,[3] is increasing from week to week: in June, 120 persons attended daily; in July, 190, of which over 60 were new patients. An average of eight new cases are being diagnosed daily.

Home-visiting, an integral part of the work at all the UNICEF/WHO tuberculosis centres, is being developed in India despite certain difficulties. It has been found that some degree of isolation of patients has proved feasible in 95% of the homes visited.

## Training Courses in Health Statistics

*Ceylon*

A 12-week course in vital and health statistics opened 19 September at Nuwara Eliya, Ceylon, under the joint sponsorship of the Government of Ceylon, the United Nations Statistical Office, and WHO. Lectures and field and laboratory projects are being followed by about 40 trainees from Afghanistan, Ceylon, India, Indonesia, Nepal, Pakistan, the Philippines, and Thailand.

The course is being directed by Mr. K. Williams, Director-General of Censuses and Statistics, Ceylon; Mr. A. J. Joseph, Assistant Permanent Secretary of the Ceylon Ministry of Health, is serving as Secretary. Among the lecturers are: Dr. W. T. Fales, WHO consultant in health statistics and research associate at Johns Hopkins School of Hygiene and Public Health (USA); Dr. S. Swaroop, Chief of the Statistical Studies Section of WHO (Geneva); Dr. Erb na Bangxang, Health Statistics Officer of the WHO Regional Office for South-East Asia (New Delhi); and Mr. C. K. Dilwali and Miss N. P. Powell, both of the United Nations Statistical Office (New York).

*Egypt*

Forty statisticians from 17 Eastern Mediterranean countries are attending a training course in vital and health statistics at Cairo, Egypt. The course, which began 8 October and which will continue to 8 December, is being sponsored jointly by the Egyptian Government and certain agencies and offices of the United Nations—the Technical Assistance Administration, the United Nations Statistical Office, and WHO. It has been organized at the request of governments in the Eastern Mediterranean Region which participated at a regional conference on health statistics in September 1950.[4]

Mansour Mashaly Bey, Director-General of Statistics in Egypt, has been appointed Director of the training course; Mr. O. Cabello (Chile), of the United Nations Statistical Office, is serving as Assistant Director, in charge of co-ordination of administrative and technical matters. Emphasis in the course is on practical aspects of vital and public-health statistics, with laboratory and field work playing an important part in the training.

[3] *Chron. World Hlth Org.* 1951, 5, 62
[4] *Chron. World Hlth Org.* 1950, 4, 342

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